

**Oasis Colon Hydrotherapy Client Information & Medical History**

**PERSONAL HISTORY:**

**Client Name: Phone Number: Today’s Date:**

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**Home Address: City: State: Zipcode:**

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**Date of Birth: Age: Occupation:**

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**Height: Weight: Female: Male: Marital Status:**

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**Emergency Contact Name: Phone Number:**

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**How did you find out about Oasis Colon Hydrotherapy:**

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**MEDICAL HISTORY:**

**Are you currently under the care of a physician? (circle one) If yes, what for?**

| **Y or N** |  |
| --- | --- |

**Do you have a prescription for this visit? (circle one) If yes, do we have a copy on file?**

| **Y or N** | **Y or N** |
| --- | --- |

**Is Colon Hydrotherapy part of a protocol that a healthcare professional has referred or prescribed for you?**

| **Y or N** | **If yes, name and type of doctor:** | **Reason:** | **Referral**  **Date::** |
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**Do you have any of the following conditions? Please circle all that apply:**

| **Abdominal Hernia**  **Acute Liver Failure**  **Cardiac Conditions**  **Crohn’s Disease**  **Fissures/Fistulas**  **Lupus**  **IBS/ Bloating**  **Parasites** | **Constipation**  **Abdominal Surgery**  **Anemia**  **Colitis**  **Hemorrhaging**  **Pregnant**  **AIDS**  **Blood in stool** | **Diarrhea**  **Rectal Bleeding**  **Abnormal Distension**  **Aneurysm**  **Dialysis patient**  **Hemorrhoidectomy**  **Rectal/Colon surgery**  **Diverticulitis** | **Infectious Disease**  **Hepatitis B or C**  **Cancer of the Colon**  **Intestinal Perforations**  **Renal Insufficiencies**  **Bladder Infection**  **Itching Anus**  **Hemorrhoids** |
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**Do you have any communicable diseases?**

| **Y or N** | **If yes, explain:** |
| --- | --- |

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**Do you have any other health problems or medical conditions?**

| **Y or N** | **If yes, please list:** |
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**MEDICATIONS & SUPPLEMENTS:**

**List all you now take regularly including over the counter meds:**

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| **Do you take digestive aids/laxatives? Y or N** | **If yes, describe:** |
| --- | --- |

| **Are you on any Steroids?**  **Y or N** | **If yes, injections or oral?** |
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| **Are you on any blood thinners? Y or N** | **Are you on any diuretics? Y or N** |
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**When was the last time you were on an antibiotic and why?**

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**ADDITIONAL INFORMATION:**

| **Describe your regular routine for exercise:** |
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**On a scale of 1 to 10 where, 1 = can’t get of bed and 10 = optimal energy. Rate your normal energy level:\_\_\_\_**

**How many servings of vegetables do you eat per day?\_\_\_\_ How many servings of fruit do you eat daily?\_\_\_\_\_**

**How much water do you drink daily? \_\_\_\_\_\_\_\_\_ How much dairy do you eat per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How much meat do you eat per day or week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **Do you smoke?**  **Y or N** | **If yes, how much daily and for how long?** |
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| **Do you drink alcohol?**  **Y or N** | **If yes, how much daily and for how long?** |
| --- | --- |

**How often do you have a bowel movement? Please share how many daily and if you skip days.**

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**Color and consistency of bowel movements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What do you hope to achieve from this Colon Hydrotherapy session?**

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| **Do you have specific concerns?**  **Y or N** | **If yes, explain:** |
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**My signature below indicates that I have honestly answered all of the questions above and supplied any additional relevant information within this intake form.**

| **Client Name(Printed clearly):** | **Client Signature:** | **Date:** |
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